Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: CENTRE FOR NEURO SKILLS 2658 MT VERNON AVENUE BAKERSFIELD CA 93306	MFDR Tracking #: M4-10-4618-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: INSURANCE CO OF THE STATE OF PA REP BOX #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "The Insurance carrier, Insurance Company of the State of Pennsylvania (AIG), the TPA – Sedgwick Claims Management Services, and the predecessor, Travelers Insurance Company, agreed to the provider/requestor's rates and approved the essential and necessary services for the patient, [injured employee]. These fair and reasonable charges were agreed upon by the carrier, employer, and the provider (Centre for Neuro Skills®). These essential and necessary services have been provided for the patient [injured employee] since he entered the Centre for Neuro Skills® residential program on December 6, 1994. In 2008, and for the last fifteen (15) years, the patient has continued to receive these essential and necessary services and, as they are charged at the fair and reasonable rate agreed upon between the parties, these rates should be paid under rule 134.401(a)(2)."

Principal Documentation:

1. DWC060
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $14,610.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Respondent requests a dismissal of all dates of services included within this dispute because they were not timely filed in accordance with DWC Rule 133.307(c)(1)(A). The DWC-60 shows that this dispute was received by TDI-DWC Medical Fee Dispute Resolution on July 6, 2010; therefore, the dates of service June 1, 2009 through June 15, 2009 would not have been timely filed. Requestor is not owed reimbursement because this matter was not timely filed per DWC Rule 133.307(c)(1)(A). Additionally, Requestor is not owed any reimbursement because of its failure to submit a claim for payment within 95 days of the date of service. The only bill received by Respondent is the one attached in which Requestor wrote a letter on February 9, 2010 attaching a copy of the medical bill. This medical bill is properly denied since it was not received within 95 days of the date of service."

Principal Documentation:

1. DWC060

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
06/01/09 – 06/30/09	29, W1, 937	CPT Code 97799	$14,610.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason codes:
   - 29 – The time limit for filing has expired;
   - W1 – Workers Compensation State Fee Schedule adjustment; and
   - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

2. In accordance with 28 Tex. Admin. Code Section §133.307(c)(1)(A) the Requestor has not submitted the request for medical fee dispute resolution within one year of the disputed dates of service. The disputed dates of service are listed as June 1, 2009 through June 30, 2009; the Division received the dispute July 6, 2010. Therefore, per Tex. Admin. Code Section §133.307(e)(3)(E) the request for medical fee dispute resolution is untimely and outside the jurisdiction of Medical Fee Dispute Resolution.

3. The Division concludes that this dispute was not filed in the form and manner prescribed under §133.307. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		August 16, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.